# Michigan Medicaid Database Explanation

This document contains information for interpreting the Michigan Medicaid Databases listed below. Each database contains a listing of the covered procedure codes for each provider group, a status code, the current fee(s) or ABU (anesthesia base unit), a modifier if applicable, and in some cases, other indicators to assist with billing and coverage of services. The databases available by provider group are:

- Ambulance Services
- Anesthesia Services (CPT code range 00100 – 01999)
- Certified Nurse Midwife Services
- Chiropractic Services
- Clinical Laboratory Services
- CMHSP Children's Waiver Services
- Family Planning Clinic Services
- MSS/ISS (Maternal and Infant Support Services)
- Oral Surgeon Services
- Podiatric Services
- Practitioner and Medical Clinic Services
- School Based Services
- Vision Services

The databases are in two formats:

- PDF Excel file for viewing and/or printing a page
- WINZIP self-extracting executable Excel file for downloading data into your computer.

The databases for Ambulance, Anesthesia, MSS/ISS, Family Planning Clinics, Chiropractic, CMHSP Children's Waiver, and School Based Services include the following data elements:

- Procedure Code
- Code Description
- Status Code
- Michigan Medicaid Fee Screen (the Anesthesia database includes the ABU in place of the fee screen.)
- Parameters (Children's Waiver database only)

The databases for Practitioner and Medical Clinics, Oral Surgeons, Podiatrists, Vision, Certified Nurse Midwife, and Clinical Labs contain the above data elements along with a number of other indicators. The attached data element description explains each indicator.

The file contains one record for each unique combination of procedure code and modifier (if applicable) and is sorted in ascending order. Questions on the database should be directed to Provider Inquiry by phone at 1-800-292-2550 or by email to ProviderSupport@michigan.gov. Include your name, affiliation and phone number for contact information.

## Michigan Medicaid Database File

| Data Element | Description |
|---|---|
| **HCPCS Code** | Level I HCPCS (CPT), Level 2 HCPCS or Michigan Local code number for the service. Note: CPT codes, descriptions and two digit modifiers only are Copyright American Medical Association. All rights reserved. |
| **Modifier** | Completed when a modifier identifies a set fee screen based on RVUs or cost.<br>For diagnostic tests, a blank denotes the global service and<br>26 = the professional component<br>TC = the technical component.<br>For vision services, a blank denotes regular lenses per the code description.<br>U1 = polycarbonate lens<br>U2 = high index lens<br>55 = postoperative follow-up care only for optometrists<br>A blank will appear for services other than those identified above. |
| **Description** | The description of the service identified by the code number. For HCPCS Level I and II codes, this is the short description. Providers must refer to the CPT or HCPCS coding book for a complete description of the service. |
| **Status Code** | Indicates if a code is active (covered) when the database is published and whether additional information is required.<br>A = Active code<br>C = Hysterectomy, sterilization or abortion consent form required<br>D = Deleted code since last published database<br>M = Additional information required to process the claim such as a description of the service rendered or an operative report<br>P = Prior authorization is required |
| **NA Indicator** | An NA indicates that this procedure is rarely or never performed in the nonfacility setting. These services are covered in a facility only. |
| **Nonfacility Fee** | The fee screen for professional services provided in a nonfacility setting. If the fee is $0.01, it is individually priced and requires additional information. |
| **Facility Fee** | The fee screen for professional services provided in a facility setting. If the fee is $0.01, it is individually priced and requires additional information. |

| Data Element | Description |
|---|---|
| **PC/TC Indicator** | 0 = Physician service codes. Identifies codes that describe physician services such as visits, consultations, surgical procedures. The concept of professional and technical components does not apply. Modifiers 26 and TC cannot be used with these codes.<br>1 = Diagnostic test or radiology service. Identifies codes that describe diagnostic tests that have both a professional and technical component. Modifiers 26 and TC can be used with these codes.<br>2 = Professional component only code. This code describes the physician professional service for which there is an associated code for the technical component and the global service. Modifiers 26 and TC cannot be used with these codes.<br>3 = Technical component only code. This code describes the technical service for which there is an associated code for the professional component and the global service. Only the global or professional service only code is payable to practitioners. It also identifies codes that are diagnostic tests and have no related professional code. These services are not payable to practitioners in the facility setting. Modifiers 26 and TC cannot be used with these codes.<br>4 = Global test only code. The code describes a global service that includes both the professional and technical component for which there are associated codes that identify the professional or technical service only. These services are payable to practitioners in the nonfacility setting only.<br>5 = Incident to code. Codes that describe services that are incident to a physician service when provided by auxiliary personnel employed by the physician. Payment is not made for these services when provided to hospital inpatients or hospital outpatients.<br>6 = Laboratory physician interpretation codes. Identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. The professional interpretation only is billed with a 26 modifier. The performance of the test is billed by the laboratory and a TC modifier cannot be used.<br>7 = Physical therapy service. Payment will not be made for a patient in the hospital setting. The service is covered for practitioners only in the ambulatory setting.<br>8 = Physician interpretation codes. Identifies the professional component of a laboratory code for which separate payment will be made only if the physician interprets abnormal smears.<br>9 or blank = Not applicable. The concept of professional/technical component does not apply. |

| Data Element | Description |
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| **Global Days** | Provides time frames for follow-up care that applies to each surgical procedure.<br>000 = Endoscopic or minor procedure with related pre and post operative relative values on the day of the procedure only included in the fee screen amount. E&M services on the day of the procedure generally not payable.<br>010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative values during a 10 day postoperative period included in the fee screen amount. E&M services on the day of the procedure and during the 10-day postoperative period are generally not payable.<br>090 = Major surgery with a 1 day preoperative and a 90-day postoperative period included in the fee screen amount. Related services provided during this period generally not payable.<br>MMM = Maternity codes – usual global period does not apply.<br>XXX = The global concept does not apply.<br>ZZZ = The code is related to another service and is **always** included in the global period of the other service. |
| **Preoperative percent** | Percentage for preoperative portion of the global package. |
| **Intraoperative percent** | Percentage for intraoperative portion of the global package including postoperative work in the hospital. |
| **Postoperative percent** | Percentage for postoperative portion of global package that is provided in the office after discharge from the hospital. |
| **Bilateral Surgery (Modifier 50)** | Indicates services subject to payment adjustment for bilateral procedures.<br>0 = Payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure or there is an existing code for the bilateral procedure.<br>1 = 150% bilateral procedure payment adjustment applies when the code is reported on one line with the 50 modifier.<br>2 = RVUs are already based on the procedure being performed as a bilateral procedure. 150% bilateral payment adjustment does not apply.<br>3 = If the procedure is performed on both sides of the body on the same day, report on two claim lines with modifier RT on one and LT on the other. Payment will be the lesser of 100% of fee screen or the charge for each procedure. Procedures not identified with indicator = 3 reported this way will be rejected as duplicate services.<br>9 = Concept does not apply. |

| Data Element | Description |
|---|---|
| **Assistant Surgeon** | Indicates services that are appropriately paid as assistant surgeon services.<br>0 = An assistant surgeon may be considered for payment and supporting documentation is required to establish the circumstances requiring an assistant surgeon for this procedure.<br>1 = Assistant surgeon services are not payable.<br>2 = The procedure will be reimbursed at 16% of the fee screen if assistant surgeon services are billed.<br>9 = Concept does not apply. |
| **Co-surgeons (Modifier 62)** | Indicates services for which two surgeons, each in a different specialty, may be paid.<br>0 = Co-surgeons not permitted for this procedure.<br>1 = Co-surgeons may be paid and supporting documentation is required to establish the medical necessity of two surgeons for the procedure.<br>2 = Co-surgeons are permitted for this procedure and no documentation is required if the two specialty requirement is met.<br>9 = Concept does not apply |
| **Team Surgery (Modifier 66)** | Indicates services for which team surgeons may be paid.<br>0 = Team surgeons not permitted for this procedure.<br>1 = Team surgeons could be paid however supporting documentation is required to establish medical necessity of a team.<br>2 = Team surgeons are permitted and supporting documentation is required to explain the circumstances and members of the team.<br>9 = Concept does not apply. |